LONG TERM CARE
BED NEEDS
IN
METROPOLITAN TORONTO

METROPOLITAN TORONTO DISTRICT HEALTH COUNCIL

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FEBRUARY/84

EXECUTIVE SUMMARY

In recent years, concerns about the impact that the growing numbers of elderly would have on the health care system have been raised by health care providers and planners. For example, Metropolitan Toronto health care providers have noted that there are many "inappropriately" placed patients in acute care beds and that long waiting lists exist for admission to long term care settings.

In order to examine this situation in more detail, a Long Term Care Bed Needs Task Force was established under the Long Term Care Committee. At the same time, two other task forces were struck to examine other aspects of care for the elderly: community health and support services and the coordination of long term care services.

The largest number of long term care beds are extended care and residential care beds in nursing homes and homes for the aged. In Metropolitan Toronto, there are 8537 approved extended care and 3892 approved residential care beds. About 95% of the persons receiving care in these facilities are aged 65 or older.

Hospitals provide long term care and rehabilitation through chronic care, general rehabilitation and special rehabilitation beds. There are currently 3153 approved chronic care beds in Metropolitan Toronto. About three-quarters of the patients receiving chronic care are elderly. The number of

general and special rehabilitation beds is smaller: 760 approved general rehabilitation beds and 349 approved special rehabilitation beds. While 65% of the patients receiving general rehabilitation care are aged 65 or older, only 25% of patients receiving special rehabilitation care are elderly. Ninety-one palliative care beds are available in Metropolitan Toronto, primarily within chronic care facilities.

For all but special rehabilitation beds, the great majority of patients utilizing long term care beds in Metropolitan Toronto are Metropolitan Toronto residents.

Information was gathered from hospitals, nursing homes and homes for the aged as to the appropriateness of patient placement into long term care settings and any delays that were encountered. In a nine month period, it was found that eighty-seven percent of hospital patients who were placed into long term care settings were delayed in obtaining placement. In total, these patients waited over 150,000 days in hospital, primarily waiting for chronic and extended care beds for which the average delay for Metropolitan Toronto residents was 100.4 days and 63.6 days respectively. This is longer than delays documented for residents of other parts of Ontario.

Inaccessibility to long term care settings due to waiting lists accounted for 90 or more percent of these delays. Patients waiting for 'heavy' extended care in nursing homes waited longer than those requiring 'light' or 'medium' care. The great majority of patients did, however, receive the type of care they required.

A modified Accommodation Study was carried out in April 1983 to identify inappropriately placed patients in institutions and patients waiting for long term care in the community. One hundred and five hospitals, nursing homes and homes for the aged, encompassing 24,511 beds, took part in the study and identified about 3000 such patients.

In total, 9.7% of the patients sampled were felt to be inappropriately placed. The largest number of inappropriate placements were found in acute care beds (1090 patients or 13.9% of acute care beds if obstetric and paediatric beds are excluded). There were over 500 patients on waiting lists in the community waiting primarily for chronic and extended care.

About two-thirds of the inappropriately placed patients were on waiting lists, almost always for their optimal placement. Those patients not on waiting lists would be expected to remain where they were, in non-optimal settings. Most often, the reason for this was that the facility in which the patient was currently inappropriately placed had decided to keep the patient as long as possible.

The care needed most often by inappropriately placed patients was extended care and chronic care. There was a distinct need for 'heavy' extended care and maintenance-type chronic care. The Task Force identified a deficit of over 600 chronic care beds and 600 extended care beds for April 1983.

This deficit in chronic care beds will be partially alleviated by the completion of construction of chronic care beds at four facilities and further approval by the Ministry of Health of chronic care beds at a number of facilities that have received approval for planning. However, when allowing for a 5% decrease in the per capita need for chronic care beds, compared to current utilization rates, the 22% increase in the numbers of elderly in Metropolitan Toronto results in a need for an additional 450 chronic beds by 1993. These new beds would bring the chronic care bed total to almost 4200.

In the extended care area, the Task Force allowed for a 20% decrease in the per capita need for extended care beds. Due to the growth in the numbers of elderly, however, the Task Force projects the need for over 800 additional beds by 1993 to bring the total number to about 9700. The Task Force feels that these recommendations are, in fact, conservative and very dependend upon the introduction of alternatives to institutional care, better health promotion and coordination of services.

This study identified other problem areas such as heavy extended care, palliative care, under-utilized residential care beds, and the special needs of other care groups.

RECOMMENDATIONS FROM THE LONG TERM CARE BED NEEDS REPORT

1. THAT THE MINISTRY OF HEALTH APPROVE FOR OPERATION THE CHRONIC CARE BEDS THAT HAVE ALREADY BEEN APPROVED FOR PLANNING AT DOCTORS HOSPITAL AND WEST PARK HOSPITAL.

2. THAT THE LONG TERM CARE COMMITTEE, THROUGH THE METROPOLITAN TORONTO DISTRICT HEALTH COUNCIL, RECOMMEND TO THE MINISTRY OF HEALTH THE ALLOCATION OF AN ADDITIONAL 450 CHRONIC CARE BEDS BEYOND THOSE ALREADY APPROVED FOR OPERATION OR PLANNING BY THE MINISTRY OF HEALTH OF WHICH ABOUT 100 SHOULD BE IN OPERATION AS SOON AS POSSIBLE, A FURTHER 300 SHOULD BE IN OPERATION BY 1988 AND A FURTHER 50 BY 1993.

3. THAT THE MINISTRY OF HEALTH AWARD THE 100 NEW EXTENDED CARE BEDS AS SOON AS POSSIBLE.

4. THAT THE MINISTRY OF HEALTH AND/OR THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES APPROVE FOR OPERATION 100 NEW EXTENDED CARE BEDS TO BE IN OPERATION AS SOON AS POSSIBLE, AND A FURTHER 430 TO BE IN OPERATION BY 1988 AND A FURTHER 300 BY 1993.

5. THAT THE MINISTRY OF HEALTH WORK WITH PROVIDERS TO REVIEW THE DEFINITIONS OF LIGHT, MEDIUM AND HEAVY EXTENDED CARE AND TO DEVELOP MEANS OF CLASSIFYING EXTENDED CARE PATIENTS INTO THESE LEVELS. FURTHER, THAT THE MINISTRY OF HEALTH FUND FACILITIES PROVIDING EXTENDED CARE ACCORDING TO THE NUMBER OF PATIENTS FITTING EACH OF THESE CLASSIFICATIONS.

6. THAT THE MINISTRY OF HEALTH REVIEW ITS DEFINITIONS OF GENERAL AND SPECIAL REHABILITATION IN ORDER TO REFLECT THE SPECIAL NEEDS OF THE ELDERLY POPULATION.

7. THAT THE LONG TERM CARE COMMITTEE EXAMINE THE SPECIAL LONG TERM CARE BED NEEDS OF THE YOUNG DISABLED.

8. THAT THE LONG TERM CARE COMMITTEE EXAMINE THE SPECIAL LONG TERM CARE BED NEEDS OF OTHER CARE GROUPS SUCH AS THE PATIENTS WITH CHRONIC NEUROLOGICAL DISORDERS, CHRONIC PSYCHIATRIC DISORDERS AND OTHERS.

9. THAT THE LONG TERM CARE COMMITTEE WORK WITH THE PALLIATIVE CARE WORK GROUP OF METROPOLITAN TORONTO TO EXAMINE AND DEVELOP A COMPREHENSIVE RANGE OF APPROPRIATELY-FUNDED PALLIATIVE CARE SERVICES (COMMUNITY AND INSTITUTIONAL) THROUGHOUT METROPOLITAN TORONTO.

10. THAT THE MINISTRY OF COMMUNITY AND SOCIAL SERVICES ESTABLISH A TASK FORCE WITH CHARITABLE AND MUNICIPAL HOMES FOR THE AGED AS WELL AS THE PRIVATE RESIDENTIAL CARE FACILITIES TO EXAMINE THE CURRENT ROLE OF RESIDENTIAL CARE BEDS AND DEVELOP, WHERE NECESSARY, MORE APPROPRIATE ROLES AND FUNCTIONS FOR EXISTING BEDS, SUCH AS THE POSSIBLE CONVERSION TO EXTENDED CARE.

LONG TERM CARE BED NEEDS TASK FORCE

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Humber Memorial Hospital

Mrs. Virginia Allison
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LONG TERM CARE BED NEEDS IN METROPOLITAN TORONTO

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FORMAT OF THE REPORT

This report begins with an Introduction (Chapter 1) and Background (Chapter 2). The remaining chapters describe the Study Approach (Chapter 3), Findings (Chapters 4 to 6), Assessment of the Long Term Care Bed Situation (Chapter 7) and Conclusions and Recommendations (Chapter 8). Because of the detailed nature of the Report, an Executive Summary has bee included at the beginning of some chapters to highlight their contents. The title page for each chapter also indicates the appendices that can be consulted for further details.

Chapter One:

INTRODUCTION

INTRODUCTION

In recent years, concerns about the impact that the growth in the numbers of elderly would have on the health care system have been raised by health care providers and planners throughout North America. Since institutional services are already strained, and will soon be strained further, attention has focused on the development of community-based alternatives and better means of coordinating existing services. It is expected, however, that considerable difficulties will remain in providing adequate long term institutional care, even after the implementation of these alternatives.

Many elderly persons find it increasingly difficult to retain their independence in the community. For those whose physical and mental faculties decline, the assistance of family, friends and community support services is drawn upon. Economic problems also diminish the capability of the elderly to live independently in the community as inflation erodes their savings and pensions.

A combination of the above problems or a crisis situation, such as the death of a spouse or an acute illness, can lead to admission to a health care facility.

One result of the increased admission of elderly persons to health care facilities has been a high level of "inappropriate" placement, particularly of long term care patients in acute care beds. Some of these patients no longer require acute care but are awaiting transfer to more appropriate long term care facilities.

These delayed transfers create serious problems for hospitals. Due to bed blockages, physicians in acute care hospitals find their ability to admit new patients is restricted, and elective surgeries are cancelled. Acutely-ill patients arriving at emergency departments often cannot be admitted. The public reacts negatively when it perceives its local hospitals as being unable to serve the community's health needs.

Inappropriate placement can also occur within levels of long term care: in chronic, rehabilitation, extended and residential care beds when, again, the patient's condition may have changed but blockages prevent transfer to more appropriate settings. Long term care administrators note long waiting lists of persons in the community, lodging houses, or in other institutions.

The true victims of the current situation are, of course, the persons waiting for transfer or admission and their families. These patients can develop new problems or display emotional, physical and social regression while waiting for more appropriate placements. These new problems can create serious problems for families.

The situation is further complicated by unclear definitions as to the type of patients who require various types of care. In particular, there is confusion between heavy extended care and chronic care and between general and special rehabilitation. Furthermore, there is concern about the ability of various health professionals to properly assess the needs of geriatric patients in arriving at appropriate placement decisions.

The study will examine and make recommendations regarding the long term care bed situation in Metropolitan Toronto.

Chapter 2:

BACKGROUND

BACKGROUND

EARLIER STUDIES

A number of studies have examined long term care bed needs in Metropolitan Toronto during the past two decades. The most recent of these was the 1980 University Teaching Hospitals Association/Hospital Council of Metropolitan Toronto (UTHA/HCMT) Report of the Long Term Care Needs Committee (Phase I). The purpose of this study was to obtain an interim assessment of the long term care bed situation from which to recommend a short term solution to the demand/supply problem.

The assessment was based on a snapshot survey carried out in most hospitals, nursing homes and homes for the aged in Metropolitan Toronto and some surrounding areas. The study recommended the addition of 499 chronic and 2099 extended care beds to Metropolitan Toronto by 1985.[1]

While the Minister of Health, at that time, agreed that there was a shortage of chronic and extended care beds, differences of opinion existed between Ministry of Health and UTHA/HCMT staff as to the actual number of additional beds required.[2]

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[1] University Teaching Hospitals Association/Hospital Council of Metropolitan Toronto, Report of the Long Term Care Needs Committee (Phase I), October 1980.

[2] Comments of the Honourable Dennis Timbrell, Minister of Health, to the Hospital Council of Metropolitan Toronto, January 11, 1981.

Subsequent meetings revealed that the Ministry of Health had fundamental concerns with the methodology through which the survey was conducted. Some of the expressed concerns included the lack of orientation of assessors, lack of intermediate documentation of patients assessed, gross sampling of waiting lists and the rate of non-response from some institutions.

THE METROPOLITAN TORONTO DISTRICT HEALTH COUNCIL

Long term care of the elderly is one of the top priorities of the Metropolitan Toronto District Health Council, resulting in the formation of a Long Term Care Committee.

Following a review of the Ministry of Health's concerns with the UTHA/HCMT Study, the Long Term Care Committee decided in April 1982 to do another study of long term care bed needs. Several working group meetings were held to discuss the possible methods by which this could be accomplished (described in the section on Selection of Study Methodologies below), followed by the establishment of a Task Force on Long Term Care Bed Needs in November 1982. The Terms of Reference and Membership of this Task Force were approved by the Executive Committee of Council in February, 1983, and are attached. The Task Force met 17 times between November 1982 and November 1983.

The Membership of the Task Force was listed earlier. It was selected to be representative of hospitals, nursing homes, homes for the aged (both municipal and charitable), consumers and the provincial government.

It should be noted that two other Task Forces of the Long Term Care Committee were also struck at this time. One was the Community Health/Support Services Task Force which examined the wide range of health and support services available in the community. The other was the Coordination of Long Term Care Services Task Force which examined how both institutional and community services might be better coordinated. These studies were funded by the Ministry of Health through Special Project grants.

LONG TERM CARE BED NEEDS TASK FORCE

TERMS OF REFERENCE

1. To assess the availability, accessibility and organization of chronic, extended (including heavy nursing), rehabilitation, residential and palliative care beds which may be required to 1990.

2. To evaluate the effectiveness of the P.A.S.S. Information System as a planning tool for long term care in Metropolitan Toronto at the end of one year of its implementation (approximately October '83).

3. To identify the information or other requirements for effective, ongoing institutional planning in the long term care area in Metropolitan Toronto.

4. To review other available data relevant to long term care bed needs.

5. To make periodic recommendations to the Long Term Care Committee on the above.

Chapter 3:

STUDY APPROACH

Details of the Study Approach are available in Appendix 1 entitled "Study Methodologies" and in Appendix 5 entitled "Validation of the Blue Run of the Placement and Support Services Information System".

STUDY APPROACH

EXECUTIVE SUMMARY

The Task Force examined the long term care bed situation in Metropolitan Toronto by reviewing the availability and utilization of existing long term care beds. This included an examination of the distribution of existing beds, their occupancy, patients' average lengths of stay, age, sex, diagnoses and home residence.

The Task Force implemented the Placement and Support Services Information System (P.A.S.S.) through which information was gathered from hospitals, nursing homes and homes for the aged for a one year time period as to the appropriateness of patient placement into long term care settings. The reasons for any inappropriate placements and delays in placement were noted. In addition, a modified accommodation study (called a "Blue Run") was performed through which any inappropriately placed patients in hospitals, nursing homes and homes for the aged were identified and assessed as to their optimal placements on one day. Patients waiting for long term care beds in the community were also identified. This latter study was validated by a team of external assessors.

The Task Force also reviewed the work of the other Task Forces on Coordination and Community Health and Support Services in order that any recommendations might be coordinated.

RANGE OF STUDY METHODOLOGIES CONSIDERED

The major objective of the Task Force was to examine the long term care bed situation in Metropolitan Toronto in terms of whether a discrepancy existed in the number and distribution of beds that were needed compared to the number that were available. If such a discrepancy existed, it was felt that it would manifest itself through the inappropriate use of existing beds and through a demand for beds by persons waiting in the community. It would be important to measure the extent of the problem and to identify its causes.

In order to arrive at an estimation of long term care bed needs, a number of factors must be considered.

First, the Ministry of Health has established provincial guidelines as to the minimum number of beds that should be available in each region of the province compared to the population. While these guidelines do not necessarily reflect "need" when applied uniformly to each region of the province, they do represent a guideline that was set up to ensure the equitable distribution of institutional services throughout the province. These guidelines are based, in part, on government policy and economic reality.

Next, it was felt to be important to analyze the utilization patterns of the existing beds within Metropolitan Toronto. This includes an examination of occupancy, average length of stay, age, sex, diagnoses and home residence of patients using existing beds. While utilization

data is readily available for most types of beds, it does not necessarily reflect the real "need" for services. Experience indicates that existing services tend to be used if alternative, more appropriate, services are not available.

It was important to examine the range of available community services in Metropolitan Toronto with a special focus on currently unavailable or under-used services that might in future have an impact on the rate of institutionalization. A detailed examination of these services was concurrently underway through the Community Health/Support Services Task Force of the Long Term Care Committee.

However, the degree of inappropriate placement within existing institutions was felt to be a major consideration in this study and one for which little data was readily available.

Inappropriate placement can be due to a number of circumstances including inappropriate referral and assessment or a change in patient condition after admission. It is commonly measured through Accommodation studies in which the institutional (hospital, nursing home, home for the aged) population of a region is assessed on one randomly-chosen, representative day by those professional staff most familiar with the patients' requirements (usually nurses and social workers in consultation with other staff). Assessments of each patient are carried out to

determine the optimal level of care required (assuming that all levels of care are available) versus the type of bed occupied. The reasons for any mismatches are noted. Alternatively, a study can be done in which only those patients who are inappropriately placed on the day of the survey are identified in terms of optimal placements and the reasons for non-optimal placement. These studies are generally combined with simultaneous waiting list surveys, in which all persons waiting in the community for long term care beds are identified. In waiting list surveys, it is important to eliminate duplicate applications, and to ensure that all persons identified are, in fact, still waiting for placement.

A combination of data from Accommodation and waiting list studies can then be used to simulate the ideal accommodation model for patients identified on that day.

Three major limitations must be recognized as being inherent in the above methods:

1. The studies record inappropriate placements at only one specific point in time. The extent to which findings can be generalized over a longer period of time depends largely on the representativeness of the day selected and the extent to which factors believed to contribute to inappropriate placement are felt to be constant.

2. Patient assessments are based on the judgement of the assessor(s) and will, therefore, reflect the personal biases of the person(s) conducting the assessments.

3. The studies focus on the institutional population and the needs of persons waiting for long term care placement in the community. They do not include people in the community who may need to be in an institutional setting but who are not on a current waiting list, for a variety of reasons.

Another method of gathering information about appropriateness of placement is the Placement and Support Services (P.A.S.S.) Information System. This system captures information on patients at the time of discharge from an institution to a long term care setting, or to the patient's home if support services are lacking, and at the time of admission into a long term care setting from the patient's home. Optimum versus actual placements are again noted as well as the reasons for non-optimum placement and delay in placement. This data is collected on an ongoing basis, and is therefore not affected by seasonal variation. While this system overcomes limitation #1 above, it is dependent upon subjective assessments and captures information on only those patients who pass through an institution.

Discussions in the early working group meetings centred around how data regarding inappropriate placements would be collected.

It was recognized that an Accommodation Study in Metropolitan Toronto would involve an assessment of about 30,000 patients in hospitals, nursing homes, homes for the aged and on community waiting lists. Prior to this assessment, it would be necessary to gain the cooperation of the majority of the institutions to take part in the study, and to orient sufficient numbers of assessors to complete the assessments in each institution on a single day in a consistent and uniform manner. After the day of the study, it would be necessary to check all forms for completeness and internal consistency. Keypunching and computer analysis would follow.

Due to the above requirements, it was determined that an Accommodation Study in Metropolitan Toronto would be expensive, time-consuming and difficult to organize, and, for these reasons, unlikely to gain the support and cooperation of the institutions that should be involved. In addition, it would be a one-day "snapshot" of the situation with limited generalizability to the actual situation. It would be necessary to repeat the study at regular intervals to ensure validity, again, a proposition that was not likely to gain acceptance. The working group felt that it is important to develop an ongoing information system that could feed into a data base to support the planning process.

SELECTION OF STUDY METHODOLOGIES

In addition to the examination of the data that was readily available, it was decided to propose the Placement and Support Services (P.A.S.S.) Information System as well as a modified accommodation study (called a "Blue Run") to all Metropolitan Toronto hospitals, nursing homes and homes for the aged. The reasons for this decision were that:

1. The system was developed in 1976 by the Ministry of Health and was already in place in 15 other District Health Council areas. The results are comparable region to region.
2. It provides information as to the appropriateness of patient placement in long term care settings on an ongoing basis, indicating the reasons for any inappropriate placements, the days of delay in patient discharge and the reasons for these delays. The data is compiled in three-month intervals.
3. Being an ongoing system, it would be possible to phase participating institutions into the system over a specific time period, allowing for adequate orientation and assistance to assessors at each institution.
4. With slight modification, the P.A.S.S. Information System forms can be utilized to perform the Blue Run through which any inappropriately placed patients are assessed on a single day, as described earlier, and incorporating a survey of patients on community waiting lists. The Blue Run would then utilize forms and definitions with which assessors were already familiar.

5. The ongoing P.A.S.S. and Blue Run data could then be analyzed in conjunction to determine the extent of inappropriate placements and delays in placement on an ongoing basis as well as at a single point in time.
6. The data would be made available to each contributing institution for its own planning and monitoring purposes.

It was recognized that the problems with the level of care definitions and the interpretation that each institution's health care professionals give to the definitions, based on their training and experience, would result in some subjectivity of assessment of optimal placement. It was felt, however, that the combined, overall picture of long term care bed needs that would emerge would be accurate. A validation of the Blue Run was proposed in order to verify the findings.

DATA COLLECTION

As mentioned above, much of the data regarding utilization of existing beds is readily available from the Ministry of Health and the Ministry of Community and Social Services. This data was compiled for each type of bed discussed. A mail-out questionnaire to hospitals and telephone interviews carried out by the Community Information Centre of Metropolitan Toronto with nursing homes and homes for the aged supplemented this information.

The major workload was the implementation of the Placement and Support Services (P.A.S.S.) Information System in Metropolitan Toronto facilities and the subsequent Blue Run. A P.A.S.S. Coordinator was hired in September 1982 for a nine month period to accomplish this task, and to facilitate communication between the participating health care facilities and the District Health Council.

a) Placement and Support Services Information System

Orientations to the P.A.S.S. Information System are usually the responsibility of the Ministry of Health. However, given the large volume of institutions entering the system from Metropolitan Toronto, they were carried out by the P.A.S.S. Coordinator following a thorough training program by Ministry of Health staff. Orientation sessions were attended by staff of all institutions joining the P.A.S.S. Information System. These 2½ hours sessions included an explanation

of P.A.S.S., a review of the level of care definitions utilized by the system and the completion of a number of case study examples. The purpose of the orientations was to ensure that those persons completing the forms would have a common understanding of the definitions of the levels of care and how to complete the forms correctly. As far as possible, orientations were organized for groups of similar institutions, for example, separate sessions for hospitals with long term care units, chronic hospitals, nursing homes and so on. This process was simplified by a phased entry of institutions to the system. Hospitals began submitting forms October 1, 1982, nursing homes began November 1, 1982, and homes for the aged began January 1, 1983.

It should be noted that participation in P.A.S.S. was voluntary at the discretion of each institution. However, the great majority of hospitals, nursing homes and homes for the aged contributed information to the system as will be discussed later.

In total, seven orientation sessions were held for hospital representatives (attended by 95 social workers and discharge planners from 43 hospitals); eight orientation sessions were held for nursing home representatives (attended by 39 directors of care and administrators from 33 nursing homes); eight orientation sessions were held for homes for the aged representatives (attended by 47 directors of care and administrators from 36 homes for the aged). These training sessions were followed by on-site sessions held at the request of the institutions. Eighteen such sessions were held at hospitals, three at nursing homes and two at homes for the aged.

Following the initial training sessions, the P.A.S.S. Coordinator was available by telephone to answer any questions as to the completion of forms. Each institution sent the completed forms to the Council on a regular basis where they were logged, reviewed and, where necessary, corrected prior to being forwarded to the Ministry of Health's Data Development and Evaluation Branch for computer analysis. This detailed monitoring by the P.A.S.S. Coordinator, which included many telephone calls to the participating institutions, ensured that facilities were completing forms correctly and accurately.

Every three months, the Ministry of Health prepared computer printouts of results by institution and area. Some of these computer tables as well as summary tables for each institution and Metropolitan Toronto (prepared by the P.A.S.S. Coordinator) were forwarded to participating facilities. The Coordinator answered any questions as to the interpretation of this data.

b) The Blue Run

The Blue Run, a modified accommodation study, was carried out on Tuesday, April 12th, 1983. The Task Force felt that, by this time, facilities participating in the ongoing P.A.S.S. Information System were quite familiar with the forms and definitions; that April 12th was a representative day, not affected by weekly or seasonal variations; and that April 12th was a midpoint between October 1, 1982 when the first institutions had entered the system, and October 1, 1983, the date to which they had committed their participation.

Although the forms for the Blue Run were similar to those in use for the ongoing system, detailed instructions were again circulated prior to the study date. Four orientation sessions were held for those wishing further clarification of the Blue Run instructions. These were attended by 79 persons from 45 institutions and were followed by 7 on-site sessions.

The P.A.S.S. Coordinator was available on April 12th to answer any questions regarding the completion of forms and, again, each form was checked for completeness and internal consistency prior to being forwarded to the Ministry of Health. Each facility later received summary sheets and selected computer tables reflecting its input to the Blue Run.

c) Validation

In addition to the detailed orientation of staff in participating facilities, the Task Force decided to perform a validation of the Blue Run to ensure that there was consistency in the way that definitions of levels of care were understood and applied in terms of "optimal placement" among the participating institutions. The validation was designed by Dr. Jack Williams, Ph.D., Director of the Health Care Research Unit at the University of Toronto. The process involved a discussion between an external validator and the assessor(s) within the institution who had completed a number of randomly selected Blue Run forms. The discussion centred on the criteria that had been used to arrive at the optimal placement decision for the patient. The validation was carried out within a 2½ week period following the Blue Run.

Chapter 4:

DESCRIPTION OF LONG TERM CARE BEDS IN METROPOLITAN TORONTO

This chapter is supplemented by Appendix 2 entitled "Definitions and Utilization Patterns of Long Term Care Beds in Metropolitan Toronto".

DESCRIPTION OF LONG TERM CARE BEDS IN METROPOLITAN TORONTO

EXECUTIVE SUMMARY

This report deals with six types of long term care beds as described in the terms of reference.

The largest number of long term care beds are extended care and residential care beds in nursing homes and homes for the aged. In Metropolitan Toronto, there are 8537 approved extended care and 3892 approved residential care beds. About 95% of the persons receiving care in these facilities are aged 65 or older.

Hospitals provide long term care and rehabilitation through chronic care, general rehabilitation and special rehabilitation beds. There are currently 3153 approved chronic care beds in Metropolitan Toronto. About three-quarters of the patients receiving chronic care are elderly. The number of general and special rehabilitation beds is smaller: 760 approved general rehabilitation beds and 349 approved special rehabilitation beds. While 65% of the patients receiving general rehabilitation care are aged 65 or older, only 25% of patients receiving special rehabilitation care are elderly. Ninety-one palliative care beds are available in Metropolitan Toronto, primarily within chronic care facilities.

For all but special rehabilitation beds, the great majority of patients utilizing long term care beds in Metropolitan Toronto are Metropolitan Toronto residents.

CHRONIC CARE

According to Ministry of Health definitions, this type of care is required by a person who

> is chronically ill and/or has a functional disability (physical or mental) whose acute phase of illness is over, whose vital processes may or may not be stable, whose potential for rehabilitation may be limited, and who requires a range of therapeutic services, medical management and skilled nursing care plus provision for meeting psychosocial needs. The period of time during which care is required is unpredictable but usually consists of a matter of months or years. Chronic care patients may require maintenance, rehabilitation, psychiatric or terminal care.

There are currently 3153 approved chronic care beds in Metropolitan Toronto, but 3191 are operational. An additional 359 beds have been approved for operation and are scheduled to be in operation by 1986, bringing the total number of approved chronic care beds to 3512. Over half of the existing beds are located in the City of Toronto. According to the Ministry of Health minimum guidelines, Metropolitan Toronto should have 2812 beds in 1982 and 3119 beds in 1987.

During 1981/82, the occupancy in these chronic care beds ranged from 93.2% to 120.4%. The average length of stay ranged from 116 to 450 days. However, 27.9% of patients were separated in less than one month and 67.9% in less than 6 months. Of the patients in chronic care beds in Metropolitan Toronto on March 31, 1983, 25.1%

were under age 65, 17.6% were 65 to 74, and 57.3% were 75 or older. In total, 58.5% were female. Of those 75 or older, 67.3% were female. Of these same patients, 90.8% were residents of Metropolitan Toronto and 5.3% were residents of Durham, York, or Peel Regions. 96.7% of Metropolitan Toronto residents who received chronic care in 1981/82 received it in Metropolitan Toronto facilities.

The major diagnoses of Metropolitan Toronto residents separated from chronic care beds in 1981/82 were diseases of the circulatory system, psychoses, and fractures.

GENERAL REHABILITATION

General rehabilitation beds are defined by the Ministry of Health under acute care as that care required by a patient who

> is in the immediate recovery phase or who is convalescing following an accident, illness or injury and who requires a planned and controlled therapeutic and educational program of comparatively short duration.
>
> Patients convalescing from orthopaedic surgery and the majority of strokes usually receive the therapeutic care necessary in general rehabilitation beds.

There are currently 760 approved general rehabilitation beds in Metropolitan Toronto although only 667 are operational. An additional 60 beds have been approved for operation and are scheduled to be in operation by 1986, bringing the total number of approved general rehabilitation beds to 820. None of the beds are in East York, Etobicoke, or York. According to Ministry of Health minimum guidelines, Metropolitan Toronto should have 314 beds in 1982 and 318 beds in 1987.

During 1981/82, the occupancy in these beds ranged from 85.4% to 123.8%. The average length of stay ranged 29 days to 96 days. Of the patients in general rehabilitation beds on March 31, 1983, 35.1% were under age 65, 26.6% were 65 to 74, and 38.3% were 75 or older. In total, 67.6% were female. Of these same patients, 80.5% were residents of Metropolitan Toronto, 7.3% were residents of Durham, York, or Peel Region.

The major diagnoses of patients separated from general rehabilitation beds during 1981/82 were fracture of the lower limb, osteoarthritis, cataract, cerebrovascular diseases, fracture of the neck and trunk and acute myocardial infarction.

SPECIAL REHABILITATION

According to Ministry of Health guidelines, special rehabilitation is required by a person with

> relatively stable disability such as congenital defect, post-traumatic deficits or the disabling *sequelae* of disease, which is unlikely to be resolved through convalescence or the normal healing process, who requires a specialized rehabilitative program to restore or improve functional ability. Adaptation to this impairment is an important part of the rehabilitation process. Emotional problems may be present and may require psychiatric treatment along with physical restoration. The intensity and duration of the care is dependent on the nature of the disability and the patient's progress, but maximum benefits usually can be expected within a period of several months.

Special rehabilitation services are usually required by such patients as those with traumatic paraplegia or quadriplegia, younger patients with severe strokes and patients with severe head injuries.

There are currently 349 approved special rehabilitation beds in Metropolitan Toronto of which 333 are operational. None of these beds is in East York, Etobicoke, or Scarborough. No further approvals for special rehabilitation beds have been granted. According to Ministry of Health minimum guidelines, Metropolitan Toronto should have 364 beds in 1982 and 382 beds in 1987.

During 1981/82, the occupancy in these special rehabilitation beds ranged from 58.9% to 88.6%. The average length of stay ranged from

28 to 74 days. Of the patients in special rehabilitation beds on March 31, 1983, 75.7% were under age 65, 14.2% were 65 to 74, and 10.1% were 75 or older. In total, 63.7% were male. Of these same patients, 64.4% were residents of Metropolitan Toronto and 13.5% were residents of York, Durham, or Peel Regions. Twenty-two point one percent are from other parts of Ontario or Canada.

EXTENDED CARE

According to Ministry of Health definitions, this type of care is required by a person with

> a relatively stabilizes (physical or mental) chronic disease or functional disability, who, having reached the apparent limit of his recovery, is not likely to change in the near future, who has relatively little need for the diagnostic and therapeutic services of a hospital but who requires availability of personal care on a continuing 24-hr. basis, with medical and professional nursing supervision and provision for meeting psycho-social needs. The period of time during which care is required is unpredicatable but usually consists of a matter of months or years.

There are currently 8537 approved extended care beds in Metropolitan Toronto: 5621 in nursing homes, 2916 in homes for the aged. A further 220 have been approved for operation and an additional 100 extended care beds have been announced but not yet tendered. The largest number of beds are in the City of Toronto (about 2800), Scarborough (about 2000), and North York (about 2000). According to Ministry of Health minimum guidelines, Metropolitan Toronto should have about 8000 extended care beds.

The occupancy within nursing homes is very close to 100% with waiting lists at most facilities. Ninety-two point eight percent of nursing home patients were age 65 or older and almost 50% were 85 or older in March, 1983. Little information is available as to home residence of patients as they are considered to be residents of the area where the home is located. However, of those patients placed into Metropolitan

Toronto nursing homes and documented by P.A.S.S. October 1982 through June 1983, 94.3% were Metropolitan Toronto residents.

The occupancy in extended care beds in homes for the aged is also close to 100%. 98.5% of extended care patients in homes for the aged were age 65 or older while over 50% were 85 or older in March, 1983. Of the patients placed into Metropolitan Toronto homes for the aged from October 1982 through June 1983, and documented by P.A.S.S. P.A.S.S., 97.8% were residents of Metropolitan Toronto.

Heavy Extended Care

In recent years, it has become evident that a group of patients exists that fits neither into extended care nor chronic care. These patients are the 'heavy' extended care patients who require in excess of 2½ hours nursing and personal care per day.

The minimum weekly nursing and personal care to be given to each nursing home resident according to the Nursing Home Act is:

Registered Nurse
Registered Nursing Assistant
Health Care Aide

or an average 1.5 total hours per day. There is no upper limit on the number of hours of care per day.

In order to identify extended care needs more clearly, extended care was divided into three types for purposes of this study:

light (persons requiring 1½ to 2 hours care per day)
medium (persons requiring 2 to 2½ hours care per day)
heavy (persons requiring 2½ or more hours care per day)

Information was collected about heavy extended care throughout the study.

RESIDENTIAL CARE

According to Ministry of Health guidelines, residential care is required by a person who

> is ambulant and/or independently mobile, who has decreased physical and/or mental faculties, and who requires primarily supervision and/or assistance with activities of daily living and provision for meeting psycho-social needs through social and recreational services. The period of time during which care is required is indeterminate and related to the individual condition.

Although residential care may be provided in rest homes, boarding homes, lodges and other facilities, for purposes of this study, its examination was limited to homes for the aged and satellite homes for the aged.

There are currently 3427 approved residential care beds in homes for the aged and 465 in satellite homes in Metropolitan Toronto. The largest number of these residential care beds is in the City of Toronto (about 1400). There are no Ministry of Community and Social Services guidelines for the number of residential care beds that should be available in Metropolitan Toronto. In April 1983, the average occupancy in residential care beds was 87.7%. Ninety-five point four percent of patients in residential care beds in homes for the aged were 65 or older and 36.0% were 85 or older in March 1982. Patients are considered to be residents of the area where the home is located.

PALLIATIVE CARE

Palliative care is the provision of therapeutic services designed to address the physical, psycho-social and spiritual needs of dying patients and their families. Although prolongation of life is not a goal, control of symptoms may accompany or revive the prospect of further active treatment and indeed prolong life. The majority of patients likely to require palliative care are cancer patients.

Palliative care services may be provided in the community or in institutions. Within institutions, services can be available in geographically distinct units, or throughout the institution through special palliative care teams. Patients may also receive care at home. Bereavement follow-up services for friends and relatives of deceased patients are recommended.

In general, palliative care is provided by a co-ordinated, multi-disciplinary team. The unit of care is the patient and family/friends. Control of symptoms is a prime objective.

There are 91 designated palliative care beds primarily within chronic care facilities in Scarborough and the City of Toronto.

Chapter 5:

RESULTS OF PLACEMENT AND SUPPORT SERVICES (P.A.S.S.) INFORMATION SYSTEM

The detailed results are available in Appendix 3 entitled "Results of P.A.S.S. October 1, 1982 to June 30, 1983".

RESULTS OF PLACEMENT AND SUPPORT SERVICES (P.A.S.S.) INFORMATION SYSTEM
October 1, 1982 to June 30, 1983

EXECUTIVE SUMMARY

Information from the P.A.S.S. Information System identified major long term care problem areas. Eighty-seven percent of hospital patients who were placed into long term care settings during a 9 month period were delayed in obtaining placement. In total, these patients waited over 150,000 days in hospital, primarily in acute care beds. The longest delays were accounted for by patients waiting for chronic and extended care beds for which the average delay for Metropolitan Toronto residents was 100.4 days and 63.6 days respectively. This is longer than delays documented for residents of other parts of Ontario.

Inaccessibility to long term care settings due to waiting lists accounted for 90 or more percent of these delays. Patients waiting for 'heavy' extended care in nursing homes waited longer than those requiring 'light' or 'medium' care. The great majority of patients (87.5%) did, however, receive the type of care they optimally required.

In addition to the patients who received placements in long term care settings during this time, about 700 Metropolitan Toronto residents died in hospital while awaiting long term care settings. These patients had waited about 35,000 days at the time of death.

The great majority of patients (78.9%) documented in this study were aged 65 or older and 64.5% were women.

INTRODUCTION

Ninety-seven hospitals, nursing homes and homes for the aged took part in the P.A.S.S. Information System during a one-year period, from October 1, 1982 to September 30, 1983. Due to the time required for the processing of information, the final three months' data was not available at the time of writing this report. This section will, therefore, highlight the results of a nine month period, from October 1, 1982 to June 30, 1983. The final three months' data will be added to the data base of the Long Term Care Committee.

P.A.S.S. forms were completed on patients whenever they were discharged or transferred to a long term setting, or to their own homes (if support services were lacking, or a delay occurred in transfer), and whenever they were admitted from home to a long term care setting. Five thousand two hundred and seventeen forms were completed for Metropolitan Toronto residents during this nine month period.

DEFINITIONS

A number of definitions used in the system are important in understanding the data and are outlined below:

Date Ready for Discharge or Transfer

"The date identified by the physician or other responsible person that the client was ready for discharge or transfer. If 'as soon as possible' or 'ready for discharge' is stated, use this date."

Optimum Placement Accommodation

"Is the most suitable setting to which the client could be discharged or transferred, IF ALL ALTERNATIVES WERE AVAILABLE. The decision as to the optimum placement should, if possible, be one involving the client, the family and treatment staff familiar with the patient, eg. nurse, occupational therapist, physiotherapist, physician, social workers, etc."

The following results are all for Metropolitan Toronto residents unless otherwise stated.

DELAYS IN PLACEMENT

- 87.0% of hospital patients who were placed into long term care settings were delayed in obtaining placement (3777 of 4342 patients).

- These patients waited a total of 151,266 days in hospital, of which 120,425 days were spent in acute care beds and 18,988 days in chronic care beds.

- The longest delays were accounted for by hospital patients waiting for chronic and extended care beds (61,938 and 51,866 days respectively).

- When province-wide P.A.S.S. results are compared, a larger percentage of Metropolitan Toronto residents were delayed in obtaining placement from hospital for every type of long term care setting than the patients from all other Ontario counties. (It should be noted that not all Ontario counties contributed data to P.A.S.S. during this time interval.)

	METROPOLITAN TORONTO RESIDENTS	RESIDENTS OF OTHER PARTS OF ONTARIO
TOTAL PLACEMENTS FROM HOSPITAL (October 1, 1982 to June 30, 1983)	4,342	6,626
PERCENTAGE OF DELAYED PLACEMENTS		
CHRONIC CARE BED	96.0%	82.2%
EXTENDED CARE BED	91.2%	72.5%
RESIDENTIAL CARE BED	77.7%	44.5%
OTHER SUPERVISED CARE	93.4%	77.4%
OTHER INSTITUTIONAL CARE	86.9%	82.0%
INDEPENDENT CARE	72.4%	63.8%

- For two of these settings, average delays from hospital were longer for Metro Toronto residents than the residents of other counties:

	METROPOLITAN TORONTO RESIDENTS	RESIDENTS OF OTHER PARTS OF ONTARIO
CHRONIC CARE BED	100.4 days	63.6 days
EXTENDED CARE BED	63.6 days	55.9 days

- For the other four types of settings, Metro Toronto residents experienced shorter delays from hospital than the others:

	METROPOLITAN TORONTO RESIDENTS	RESIDENTS OF OTHER PARTS OF ONTARIO
RESIDENTIAL CARE BED	35.2 days	36.1 days
OTHER SUPERVISED CARE	27.9 days	33.2 days
OTHER INSTITUTIONAL CARE	11.4 days	18.6 days
INDEPENDENT CARE	25.0 days	32.0 days

- 78.4% of patients who were placed into long term care settings from other than hospitals were delayed in placement (686 of 875 patients) and waited 38,151 days. The longest delays were experienced by those waiting for chronic and extended care beds (6,360 and 22,823 days respectively).

- The actual delays for placement into each type of long term care ranged from a very short time period of 1 to 5 days, to over 500 days for chronic and extended care as shown in Table 5I. The median length of time waited for each type of care is marked. This chart includes all delayed placements (i.e. from hospital and other settings).

Table 5i FREQUENCY DISTRIBUTION OF DAYS OF DELAY

Actual Placement Accommodation	(Days of Delay) 1 to 5	6 to 10	11 to 15	16 to 20	21 to 30	31 to 40	41 to 50	51 to 60	61 to 80	81 to 100	101 to 150	151 to 200	201 to 300	301 to 400	401 to 500	500+	Total Delayed Placements
	(Number of Placements)																
Residential	68	54	45	[25]	46	28	23	17	17	10	22	6	10		1		372
Extended Care	93	90	112	75	125	[96]	58	70	71	63	105	45	38	20	9	11	1081
Chronic	76	65	68	67	85	[64]	41	30	42	31	32	44	89	20	10	9	773
Special Rehab.	23	47	[41]	15	25	13	11	3	11	2			2				193
General Rehab.	688	[456]	227	88	72	32	18	7	7	6	4		2	1			1608

MEDIAN

- Inaccessibility to long term care settings due to waiting lists accounted for 90 or more percent of the delayed placements and days of delay for patients being placed into chronic, extended and other institutional settings.

- For residential, other supervised and independent settings, waiting lists accounted for the majority of delayed placements and days of delay although some delay is due to the patient and/or family being unwilling to accept placement.

- Metropolitan Toronto residents placed into nursing homes waited longer if they required heavy extended care (81.2 days) than if they required light (54.9 days) or medium (66.2 days) extended care. Patients placed into homes for the aged for extended care waited longer for light and medium care (95.0 days) than for heavy care (83.5 days). This is probably due to the pressure on homes for the aged to accept cases from the community when care is urgently needed.

- Patients placed into chronic care beds waited longest for maintenance chronic care (129.5 days), then rehabilitation chronic care (46.3 days) and least for terminal chronic care (27.6 days) or psychiatric chronic (22.5 days).

- In addition to the delays encountered by the 3777 patients who were eventually placed in long term care settings, 691 hospital and 4 community patients who were on waiting lists died prior to obtaining long term care placements. The hospital patients could be deemed to have been receiving a higher level of care than required during this time period as 663 of them were occupying acute care beds at the time of death.

- Of the hospital patients, the largest number were awaiting chronic care beds (591 patients) and extended care beds (67 patients) and had waited 31,682 and 2,762 days respectively.

- The four non-hospital patients had waited 827 days for chronic care and 33 days for extended care.

APPROPRIATENESS OF PLACEMENT

- In total, 87.5% (4,567 of 5,217) patients were placed into what were deemed to be their optimal care settings. By type of care, these percentages are:

Percentage of Patients placed into their Optimal Placements

OPTIMAL PLACEMENT	METROPOLITAN TORONTO RESIDENTS	RESIDENTS OF OTHER PARTS OF ONTARIO
CHRONIC CARE	88.3%	89.6%
EXTENDED CARE	85.5%	80.9%
GENERAL REHABILITATION	95.0%	94.0%
SPECIAL REHABILITATION	86.3%	87.9%
RESIDENTIAL CARE	81.2%	87.0%

- A number of patients did not receive their optimal placements and included:

  96 whose optimal was residential care

  194 whose optimal was extended care

  107 whose optimal was chronic care

  32 whose optimal was special rehabilitation

  94 whose optimal was general rehabilitation

- For all five types of beds, the three major reasons for non-optimal placement were: that the waiting period was too long for the optimum placement; that the client or family refused the optimal accommodation; and that the non-optimum accommodation was a temporary placement.

- Instead, these patients were placed into settings that were not optimal for them. This occurred to the largest extent for patients who went to their own homes without adequate support services (338 patients). This type of non-optimal placement is of major concern, given the large numbers of elderly persons who present themselves to emergency departments for care.

AGE, SEX AND HOME RESIDENCE

Of the 5217 Metropolitan Toronto residents identified by P.A.S.S. during the 9 month interval,

- 35.5% were male (1854 persons) and 64.5% were female (3363 persons)

- less than 1% were under 18 (7 persons)
  4.2% were 19 to 39 (218 persons)
  16.8% were 40 to 64 (874 persons)
  21.3% were 65 to 74 (1110 persons)
  35.6% were 75 to 84 (1855 persons)
  20.5% were 85 to 94 (1067 persons)
  1.6% were 95 and over (86 persons)

- 3.8% were from East York (196 persons)
  9.5% were from Etobicoke (496 persons)
  23.4% were from North York (1221 persons)
  12.9% were from Scarborough (673 persons)
  44.5% were from the City of Toronto (2322 persons)
  5.3% were from York (279 persons)
  0.6% were of unidentified residence within Metropolitan Toronto (30 persons)

CHAPTER 6:

RESULTS OF THE BLUE RUN

The detailed results are available in Appendix 4 entitled "Results of the Blue Run", Appendix 5 entitled "Validation of the Blue Run of the Placement and Support Services Information System", and Appendix 6 entitled "Calculations of Long Term Care Bed Needs in Metropolitan Toronto".

RESULTS OF THE BLUE RUN

EXECUTIVE SUMMARY

A one-day survey was carried out in April 1983 to identify inappropriately placed patients in institutions and patients waiting for long term care in the community. One hundred and five hospitals, nursing homes and homes for the aged, encompassing 24,511 beds, took part in the study and identified about 3000 such patients.

In total, 9.7% of the patients sampled were felt to be inappropriately placed. The largest number of inappropriate placements were found in acute care beds (1090 patients or 13.9% of acute care beds if obstetric and paediatric beds are excluded). There were 538 patients on waiting lists in the community (primarily waiting for chronic and extended care) and 29 patients on waiting lists for Metropolitan Toronto long term care facilities in institutions outside the region.

Of the 2669 inappropriately placed Metropolitan Toronto residents, 69.7% were on waiting lists, almost always for their optimal placement. Those patients not on waiting lists would be expected to remain where they were, in non-optimal placements. Most often, the reason for this was that the facility in which the patient was currently inappropriately placed had decided to keep the patient as long as possible.

The care needed most often by inappropriately placed patients was extended care (904 patients) and chronic care (1287 patients). Within these two types of care, there was a distinct need for 'heavy' extended care (331 patients) and maintenance-type chronic care (1017 patients).

For patients on waiting lists, the wait that they had already experienced by the day of the Blue Run increased with the heaviness of their care requirement. Patients in the community had waited a shorter time for chronic care placements than patients on waiting lists in institutions. Patients who were not on waiting lists had already been inappropriately placed for the longest time period.

Although patient assessments might have been biased according to the assessor, the results of the validation suggest that this in no way affected the overall findings.

However, it is likely that the number of patients assessed as being inappropriately placed or waiting for placement in the community is an underestimate. It is inevitable that a number of patients currently living in the community require long term institutional care, but, for a variety of reasons, have not come to the attention of a long term care setting. Secondly, since every patient in every institution was not assessed, it is likely that there were inappropriately placed patients in addition to those identified in the study.

INTRODUCTION

The Blue Run took place on Tuesday, April 12th, 1983. Its purpose was to document any inappropriately placed patients in institutions according to optimal placement, future placement, and the reason for the mismatch between the two, if any. The date on which patients became ready for discharge or transfer was also noted. In addition, any patients who were waiting for a long term care placement in the community and would accept immediate placement were documented. On the other hand, participating long term care facilities were instructed not to complete forms for patients on their waiting lists who were currently in another Metropolitan Toronto institution as these patients would be identified and documented by the institution in which they were inappropriately placed on the day of the blue run.

For the Blue Run, institutions agreed to submit patient OHIP numbers so that duplicate forms on the same patient could be removed. In these cases, the patient record that was retained was the one completed by the facility where the patient was currently inappropriately placed, as likely to be more accurate than a record completed by a facility believing the patient to be on a community waiting list, or the one completed by the first facility listed on the computer printout by OHIP numbers. For example, if a patient was found to be on several nursing home waiting lists, the first record listed would be included while the others would be discarded.

Table 6i

PARTICIPATION IN BLUE RUN BY TYPE OF BED
METROPOLITAN TORONTO INSTITUTIONS

METROPOLITAN TORONTO	Chronic Care	Extended Care	General Rehabi-litation	Special Rehabi-litation	Resi-dential	Total
(a) Total Number of Approved Beds in Completed Facili-ties	3153	8537	760	349	3892	16691
(b) Total Number of Beds Staffed and in Operation, March 31, 1983	3191	8284	667	333	3955	16430
(c) Number of These Beds In-cluded in Study (percen-tage of (b))	3156 (98.9)	7191 (86.8)	667 (100.0)	333 (100.0)	3079 (77.9)	14426 (87.8)
(d) Number of Beds Occupied April 12, 1983 (percen-tage of (c))*	3099 (98.2)	7009 (97.5)	630 (94.5)	287 (86.2)	2701 (87.7)	13726 (95.1)

* for extended care, general rehabilitation and residential care beds, a small number of facilities had a larger number of beds occupied than staffed and in operation. The actual numbers of beds occupied are included in (d) even if larger than those in (b)

PARTICIPATION IN BLUE RUN

The degree of participation in the Blue Run was very high, with 105 hospitals, nursing homes and homes for the aged, including some outside of Metropolitan Toronto, taking part. As with the ongoing P.A.S.S. Information System, no attempt was made to include residential care beds beyond those in homes for the aged.

In total, 24,511 beds were part of the survey. Of the original 3176 forms submitted, 68 were removed as having been completed in error prior to keypunching, while another 11 were removed after the first computer run, leaving a sample of 3097 forms. A total of 150 duplicate records were discarded from the sample leaving 2947 records.

The beds surveyed included all acute and acute psychiatric beds in Metropolitan Toronto except those at the Hospital for Sick Children, the Workmen's Compensation Board Hospital and the Donwood Institute. Participation among Ontario Psychiatric beds was limited to the psychogeriatric ward of Queen Street Mental Health Centre.

Over 14,000 of the beds surveyed were chronic care, extended care, general rehabilitation, special rehabilitation or residential care beds in Metropolitan Toronto. The occupancy on the day of the Blue Run in these beds ranged from 86.2% for special rehabilitation beds to 98.2% for chronic care beds (Table 6i).

Table 6ii SUMMARY RESULTS OF BLUE RUN BY TYPE OF BED FOR ALL PARTICIPATING INSTITUTIONS

Type of Bed	Occupancy April 12	Number (& percent) of Inappropriate Placements	Waiting List in Community	Waiting List in Institutions Outside Metropolitan Toronto (Duplicates removed)
Acute	8,754*	1,090 (12.5)	n/a	n/a
Chronic	3,258	343 (10.5)	214	20
General Rehab	630	50 (7.9)	1	1
Special Rehab	287	40 (13.9)	2	2
Acute Psychiatric	727	24 (3.3)	n/a	n/a
Ontario Psychiatric	994	155 (15.6)	n/a	n/a
Extended Care:				
Nursing Homes	4,417	315 (7.1)	267	6
Charitable H.F.A.	804	157 (19.5)		
Municipal H.F.A.	1,868	73 (3.9)		
Residential Care:				
Charitable H.F.A.	1,780	115 (6.5)	54	0
Municipal H.F.A.	992	18 (1.8)		
TOTAL	24,511	2,380 (9.7)	538	29

* This figure includes 915 obstetrical and paediatric beds. If it is assumed that none of these patients were among those inappropriately placed on the day of the blue run, the percentage of inappropriate placements in acute beds becomes 13.9%.

INAPPROPRIATE PLACEMENTS WITHIN INSTITUTIONS

Institutions were asked to complete forms for any inappropriately placed patients regardless of whether they were on a waiting list for other placements or expected to remain inappropriately placed. When the number of blue forms received for inpatients is compared to the occupancy of the various types of beds, a percentage of inappropriately placed patients can be calculated. This data is presented in Table 6ii for the entire sample surveyed.

By far the largest number of inappropriate placements occurred in acute care beds (1090 patients), or 13.9% of acute care beds if obstetrical and paediatric beds are excluded. The largest percentage of inappropriate placements were noted for extended care beds in charitable homes for the aged (19.5%). Overall, a level of inappropriate placements of 9.7% was observed among all participating institutions.

The number of inappropriate placements in long term care beds for Metropolitan Toronto facilities totals 1077 or 7.8% of the beds occupied. Any other patients in these beds were considered to be optimally placed (Table 6iii).

Table 6iii SUMMARY RESULTS OF BLUE RUN BY TYPE OF BED

METROPOLITAN TORONTO INSTITUTIONS

METROPOLITAN TORONTO	Chronic Care	Extended Care	General Rehabi-litation	Special Rehabi-litation	Resi-dential	Total
(e) Number of Inappropriate Placements, April 12, 1983 (percentage of (d))	319 (10.3)	535 (7.6)	50 (7.9)	40 (13.9)	133 (4.9)	1077 (7.8)
(f) * Number of Beds Needed By Appropriately Placed Patients ((d) - (e))	2780	6474	580	247	2568	12649

* It should be noted that the patients in (f) include some patients whose home residence was not within Metropolitan Toronto.

Inappropriately placed patients

Not all patients were on waiting lists for their optimal placements, or, for that matter, on waiting lists, even though they were considered to be non-optimally placed in their present accommodations. The three types of inappropriately placed patients are described below:

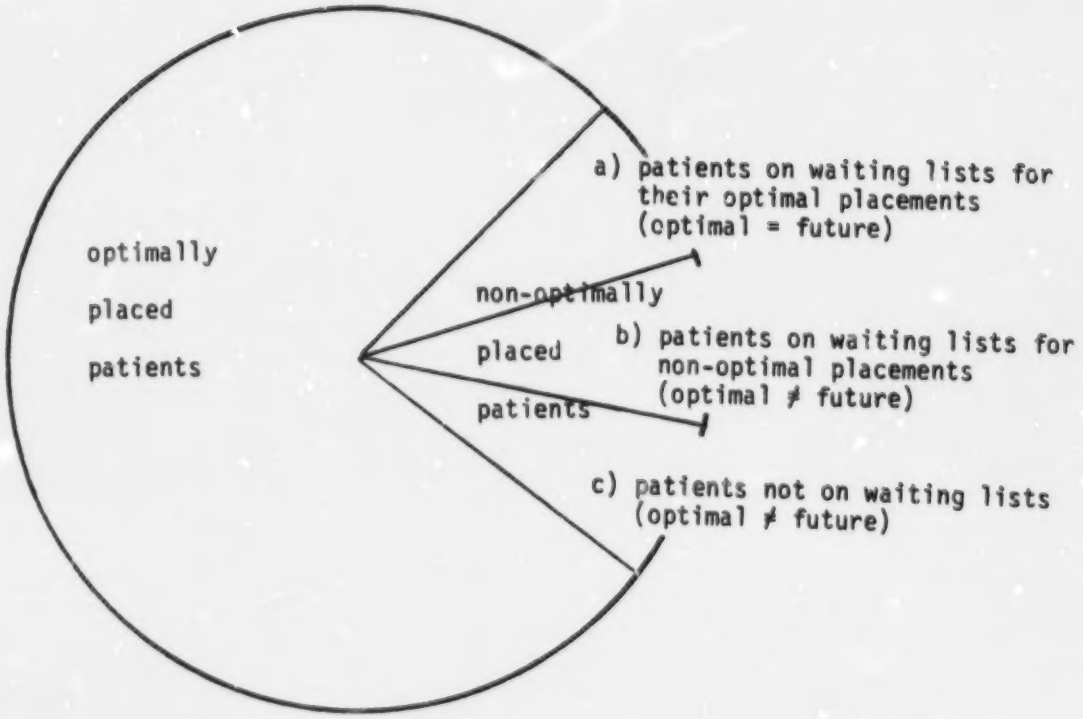

optimally
placed
patients
non-optimally
placed
patients
a) patients on waiting lists for their optimal placements (optimal = future)
b) patients on waiting lists for non-optimal placements (optimal ≠ future)
c) patients not on waiting lists (optimal ≠ future)

Table 6iv

PATIENTS ON WAITING LISTS

METROPOLITAN TORONTO SAMPLE
(Includes two patients from an unidentified city/borough)

OPTIMAL PLACEMENT / FUTURE PLACEMENT

OPTIMAL PLACEMENT	01 MFA/Ch.Inst. Res. - Light	02 MFA/Ch.Inst. Res. - Medium	03 MFA/Ch.Inst. Res. - Heavy	04 Residential Home - Light	05 Residential Home - Medium	06 Residential Home - Heavy	07 Foster Home	08 Group Home	09 Half-Way House	10 Approved Home	11 H.S.C. (Residential)	12 Other Supervised (specify)	13 Extended Care - N.H. - Light	14 Extended Care - N.H. - Medium	15 Extended Care - N.H. - Heavy	16 MFA/Ch.Inst. E.C. - Light & Medium	17 MFA/Ch.Inst. E.C. - Heavy	18 Chronic Care - Terminal	19 Chronic Care - Maintenance	20 Chronic Care - Rehab	21 Chronic Care - Psych	22 Special Rehabilitation	23 General Rehabilitation	24 Other Institutional (specify) (acute, etc.)	25 Home (without support services)	26 Boarding (no meals)	27 Boarding (with meals)	28 Home with Chronic Home Care only	29 Home with other support services (specify)	30 Other Independent (specify)	TOTAL OPTIMAL PLACEMENT
SUPERVISED																																
01 MFA/Ch.Inst. Res. - Light	38																															38
02 MFA/Ch.Inst. Res. - Medium		28											2						2													32
03 MFA/Ch.Inst. Res. - Heavy			13										1	1									1									16
04 Residential Home - Light				16									1						1													18
05 Residential Home - Medium					13																				1							14
06 Residential Home - Heavy						9													2													11
07 Foster Home							7																									
08 Group Home								7													1									1		9
09 Half-Way House									5											1	1											2
10 Approved Home										4																						4
11 H.S.C. (Residential)											1																					1
12 Other Supervised (specify)																																
INSTITUTIONAL																																
13 Extended Care - N.H. - Light		1				1							603			1			2				2							1		607
14 Extended Care - N.H. - Medium														226					9	2										1		238
15 Extended Care - N.H. - Heavy															148				16	2										1		168
16 MFA/Ch.Inst. E.C. - Light & Medium													1			121																133
17 MFA/Ch.Inst. E.C. - Heavy																	46		5						1							52
18 Chronic Care - Terminal																1		103	2											1		107
19 Chronic Care - Maintenance																4			622	4					1					2		633
20 Chronic Care - Rehab																			1	38												39
21 Chronic Care - Psych			1										1	1	1				1	1	15											21
22 Special Rehabilitation																						220	2									222
23 General Rehabilitation					1									1							1	1	103									106
24 Other Institutional (specify) (acute, etc.)																	1				1			6								8
INDEPENDENT																									6							6
25 Home (without support services)													1													2						2
26 Boarding (no meals)																											7					7
27 Boarding (with meals)	1																											1		3		5
28 Home with Chronic Care only				1	1								1	2	2	2		1	5			1										20
29 Home with other support services (specify)	1													1		2			2										29			34
30 Other Independent (specify)																															4	4
TOTAL FUTURE PLACEMENT	40	29	14	17	14	11	7	7	5	4	1	1	609	230	156	126	46	104	670	46	18	22	106	8	6	2	8	1	42	7	1664	

Note: Optimal placements are listed down the left hand side of the Table while future placements (i.e. the type of accommodation the patient was waiting for) are listed along the top of the Table. Any patient whose future placement matched his optimal placement falls along the diagonal. Any patient whose future placement differed from his optimal placement appears elsewhere on the chart. The chart includes 7 patients waiting for long term care beds in institutions outside of Metropolitan Toronto and 491 patients waiting for long term care beds in the community.

TYPES OF LONG TERM CARE ACCOMMODATION NEEDED BY INAPPROPRIATELY PLACED AND/OR WAITING PATIENTS

1860 Metropolitan Toronto residents were inappropriately placed and on waiting lists within institutions or in the community. If optimal placements are defined broadly for extended and chronic care (see Table 6iv), 1747 of 1860 patients, or 93.9% were on waiting lists for their optimal placements.

The type of care most often required by inappropriately placed patients who were on waiting lists was

1. chronic care (799 patients, of whom 633 require the "maintenance" stream)
2. extended care (694 patients, of whom 216 require "heavy" care).

809 Metropolitan Toronto residents were inappropriately placed but not on waiting lists (Table 6v). None of these patients is expected to go to his optimal placement as none was on a waiting list.

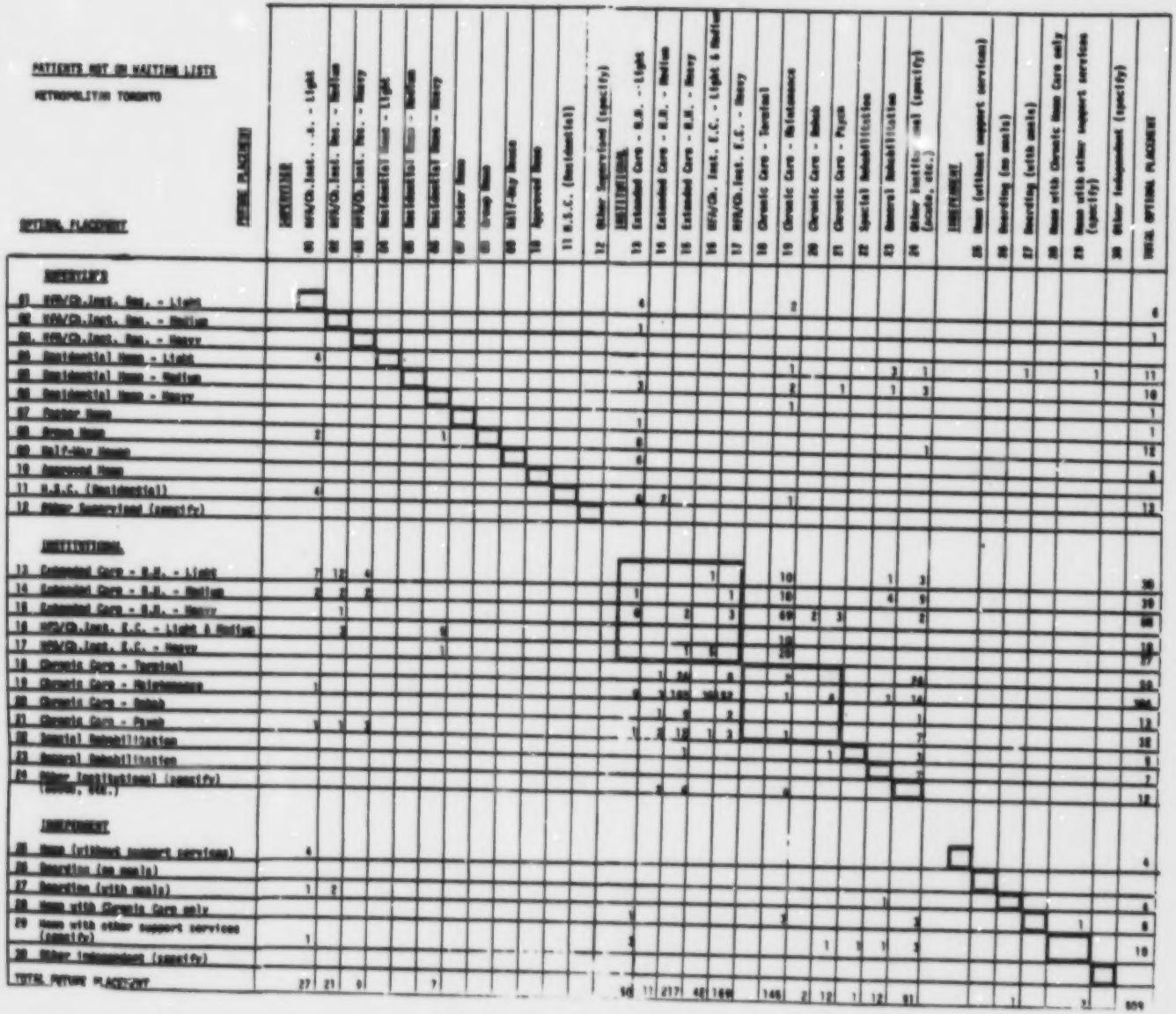
The type of care most often required by inappropriately placed patients who were not on waiting lists was again:

1. chronic care (488 patients, of whom 384 require the "maintenance" stream)
2. extended care (210 patients, of whom 115 require "heavy" care).

Table 6v

PATIENTS NOT ON WAITING LISTS

METROPOLITAN TORONTO


FUTURE PLACEMENT
PRESENT PLACEMENT
HOME
01 H/H/Ch.Inst. Gen. - Light
02 H/H/Ch.Inst. Gen. - Medium
03 H/H/Ch.Inst. Gen. - Heavy
04 Residential Home - Light
05 Residential Home - Medium
06 Residential Home - Heavy
07 Foster Home
08 Group Home
09 Half-Way House
10 Approved Home
11 R.S.C. (Residential)
12 Other Supervised (specify)
INSTITUTIONAL
13 Extended Care - R.D. - Light
14 Extended Care - R.D. - Medium
15 Extended Care - R.D. - Heavy
16 H/H/Ch. Inst. E.C. - Light & Medium
17 H/H/Ch. Inst. E.C. - Heavy
18 Chronic Care - Terminal
19 Chronic Care - Maintenance
20 Chronic Care - Rehab
21 Chronic Care - Psych
22 Special Rehabilitation
23 General Rehabilitation
24 Other Institutional (specify)
INDEPENDENT
25 Home (without support services)
26 Boarding (no meals)
27 Boarding (with meals)
28 Home with Chronic Home Care only
29 Home with other support services (specify)
30 Other Independent (specify)
TOTAL FUTURE PLACEMENT
TOTAL OPTIMAL PLACEMENT

REASONS FOR FUTURE NON-OPTIMAL PLACEMENTS

As described earlier, not all inappropriately placed patients were on waiting lists and therefore could not be expected to have a more optimal placement in the future. Even some of the patients who were on waiting lists were not waiting for their optimal placements.

Whenever the future placement accommodation differed from the optimum placement accommodation, the reason for the mismatch was determined. For patients who were on waiting lists within institutions, this occurred 107 times, and for patients on waiting lists in the community, 6 times. For patients who were not on waiting lists, the future accommodation did not match the optimal 779 times, as would be expected.

For patients who were on waiting lists, either within institutions or in the community, no single reason for non-optimum placement accounted for a significant portion of the expected mismatches. This was not the case, however, for patients who were not on a waiting list. Among this group, over one half of the expected mismatches of future and optimum placement were because the facility in which the patient was currently inappropriately placed had decided to keep the patient as long as possible (418 cases).

Table 6vi DELAYS IN PLACEMENT BY FUTURE PLACEMENT
METROPOLITAN TORONTO RESIDENTS

	Residential Care	Extended Care Light/Medium	Extended Care Heavy	Chronic Care
Patients on Community Waiting Lists	72.7 days (49 patients)	80.3 days (183 patients)	93.4 days (51 patients)	297.9 days (197 patients)
Patients on Waiting Lists Within Institutions	57.1 days (76 patients)	85.0 days (288 patients)	124.2 days (141 patients)	124.3 days (643 patients)
Patients not on Waiting Lists	361.0 days (64 patients)	378.7 days (103 patients)	318.8 days (386 patients)	466.6 days (159 patients)

DELAYS EXPERIENCED BY PATIENTS WAITING FOR PLACEMENT

The type of beds that the majority of patients were waiting for were extended, chronic and residential care beds. Patients may be waiting in institutions or in the community. Table 6vi describes how long patients had waited up until the day of the Blue Run for these beds, as well as how long other patients, not on waiting lists had spent inappropriately placed up until the day of the blue run.

Patients on community waiting lists had waited longer for heavy extended care (93.4 days) than medium or light extended care (80.3 days) and residential care (72.7 days) but waited the longest for chronic care (297.9 days). Patients waiting within institutions waited about half as long for chronic care (124.3 days) and slightly longer than community patients for extended care. Again, the wait was longer for heavy extended care (124.2 days) than for light and medium extended care (85.0 days). The patients who were not on waiting lists had been inappropriately placed for much longer periods of time, on average between 318 and 467 days for these types of care.

The delays experienced by patients waiting for residential care beds are due to requests for specific facilities or types of accommodation as residential care bed vacancies are know to exist.

AGE AND SEX OF INAPPROPRIATELY PLACED PATIENTS

Of the 2669 Metropolitan Toronto residents identified in the study, 1734 (65.0%) were female. Overall 1649 (61.8%) of the patients were 65 or older and 556 (20.8%) were 85 or older.

If these patients are examined according to whether they were on waiting lists, and if so, where they were waiting, a different picture emerges.

Of patients who were waiting in the community, 446 or 90.8% were aged 65 or older. Of those on waiting lists within institutions, 1146 or 83.7% were aged 65 or older. But of those who were not on waiting lists, only 57 or 7.0% were over the age of 65, while 81.1% were in the age group of 18 and under.

VALIDATION

Just under half of the forms submitted in the blue run were validated by external validators. It was found that the rates of agreement between assessors and validators were high (86.9%) and significantly better than one would expect by chance. The disagreements were not systematically skewed or biased. The disagreements tended to relate to the chronic and extended care levels and were within reasonable limits.

The assessors reported that they obtained information from appropriate sources to make their decisions as to optimal placements most commonly using multiple sources of information including medical records, physicians and nurses.

In conclusion, there is every reason to have confidence in the estimated number of patients with placement problems and the recommendations for optimal levels of care.

OTHER COMMENTS

Facilities that took part in the Blue Run were interviewed at the time of the validation or by a telephone interview if they were not selected for on-site validation. Staff at the facilities were asked to describe how the study was organized, what problems had been encountered and to make any other comments they wished.

In the majority of facilities, a team review of cases led to the identification of inappropriately placed patients. The types of staff most frequently involved were nurses, doctors, social workers, discharge planners and administrators. Decisions as to optimal placement were made through a review of the patients' care needs. A number of nursing homes commented that they were prepared to keep heavy care patients who might be considered to require chronic care because they had been in the home for a long time. Several nursing homes had not updated their waiting lists for years and submitted forms for only the most recent applicants.

Most facilities did not encounter problems in completing the forms although a few commented on the difficulty of determining the date ready for discharge and optimal placement.

Chapter 7:

ASSESSMENT OF THE LONG TERM CARE BED SITUATION

This chapter is supplemented by Appendix 6 entitled "Calculations of Long Term Care Bed Needs in Metropolitan Toronto".

ASSESSMENT OF THE LONG TERM CARE BED SITUATION

As discussed earlier, most inappropriately placed patients identified through the Blue Run were on waiting lists (usually for their optimal placements). Others were not on waiting lists and expected to remain inappropriately placed.

The Task Force developed a model of the number of long term care beds that would have been required on the day of the Blue Run if all patients were moved to more appropriate settings. In addition to reclassifying patients who were on waiting lists for optimal placements to the latter type of care, the Task Force made assumptions about reclassifying patients who were on waiting lists for non-optimal placements and about those who were not on waiting lists. These assumptions apply both to inappropriately placed patients within institutions and patients on community waiting lists.

Assumption 1: Patients on waiting lists for non-optimal placements:

A patient was counted according to his optimal placement if the reason he was on a waiting list for a non-optimal placement was one of the following:

> *Optimum type of accommodation available but waiting period too long*
>
> *Optimum type of accommodation or support services are not available*
>
> *This is a non-optimum temporary placement while client awaits another placement*
>
> *Optimum placement facility refused patient as "too heavy"*

These patients were counted according to optimal placement because that is where they would have been placed if it was available and accessible to them.

On the other hand, if the reason why a patient was on a waiting list for a non-optimal placement was:

> *client or family refused optimum type of accommodation or support services*

he was counted according to his future placement because he would not have gone to his optimal placement on that day even if it was available.

Assumption 2: Patients not on waiting lists

A patient was counted according to his optimal placement if the reason he was not on a waiting list was one of the following:

> *Optimum type of accommodation available but waiting period too long*
>
> *Optimum type of accommodation or support services are not available*
>
> *Optimum placement facility refused patient as "too heavy"*

If the reason for not being on a waiting list was one of the following, he was counted according to future placement:

> *Client or family refused optimum type of accommodation or support services*
>
> *Facility will keep patient in present setting as long as possible*
>
> *Patient and/or family do not wish a move. Issue is under debate at facility.*

The Task Force made a number of other assumptions in arriving at an estimate of long term care bed needs:

Assumption 3: Community Waiting Lists

The Blue Run collected information on patients on community waiting lists who were willing to accept immediate placement. Duplicate applications were vetted. The Task Force believes that the number of patients identified

was, in fact, an underestimate of actual need as no attempt was made to collect information from residential care beds other than those in homes for the aged or from patients known to public health units as requiring care but who were not on waiting lists. The full number of Metropolitan Toronto residents identified as being on community waiting lists was included in the calculations.

Assumption 4: Adjustment for Non-Participating Institutions

The Task Force considered how the findings would have differed if all chronic, extended and residential care beds had been included in the study. As it is not possible to predict this with any accuracy, it was assumed that these beds were occupied to the same level on the day of the blue run as all other beds of that type in Metropolitan Toronto. All of these patients were assumed to have been appropriately placed on the day of the Blue Run. Any patients who may have been on community waiting lists at these institutions were excluded.

Assumption 5: Optimal levels of Occupancy

In calculating the number of long term care beds needed, the Task Force adjusted for occupancy. For chronic care, extended care and general rehabilitation beds, occupancy levels on the day of the Blue Run were 94% and higher. For these, it was decided that the optimal occupancy level would be the same for each type of care as on the day of the Blue Run. For special rehabilitation and residential care, occupancy levels averaged 86 to 88%. For these, it was decided to assume an optimal occupancy level of 95%.

Conclusions

Based on the above assumptions, a large deficit in chronic and extended care beds and a slight deficit in general rehabilitation beds was identified for April 1983:

	Chronic Care	Extended Care	General Rehabi-litation	Special Rehabi-litation	Resi-dential
Beds Staffed and in Operation April, 1983	3191	8284	667	333	3955
Beds Required April, 1983	3828	8947	740	287	3703
Surplus/(Deficit) April, 1983	(637)	(663)	(73)	46	252

These results are confirmed by the findings of the P.A.S.S. Information System over a 9 month period. As described in Chapter 5, significant delays were experienced in obtaining placements in chronic and extended care beds. The days of delay encountered by waiting patients placed into or died before placement into chronic care or extended care beds were:

Type of Bed Waited For:

	Chronic Care	Extended Care
placed from hospital	61,938 days	51,866 days
placed from community	6,360 days	22,823 days
died in hospital	31,682 days	2,762 days
died in community	827 days	33 days
total days	100,807 days	77,484 days

These figures translate into 373 inappropriately placed patients requiring chronic care beds and 287 patients requiring extended care beds on any given day. While this data is not as complete as that of the blue run in that not as many institutions took part, the results are similar in their magnitude.

The ongoing P.A.S.S. Information System does not support the need for additional general rehabilitation beds. Although 1608 patients were delayed in obtaining a general rehabilitation bed during the 9 month period, the average delay was 10.2 days and one half of delayed patients were placed within 10 days while 85% of delayed patients were placed within 15 days. Ninety-five percent of patients who required general rehabilitation received their optimal placements. Most patients whose optimal placement was general rehabilitation on the day of the blue run were on a waiting list (108 of 115). Of this group, the average waiting period up to the day of the blue run had been 12.6 days, not much longer than the average delay for those placed in general rehabilitation beds during the 9 month period examined. The Task Force does not recommend any changes in the number of general rehabilitation, special rehabilitation or residential care beds at present.

Chapter 8:

CONCLUSIONS AND RECOMMENDATIONS

This chapter is supplemented by Appendix 6 entitled "Calculations of Long Term Care Bed Needs in Metropolitan Toronto".

CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

In its examination of the Long Term Care Bed Situation in Metropolitan Toronto, the Task Force has identified major problems in the availability of chronic and extended care beds. The inadequate supply of these beds has resulted in 13.9% of acute care beds being occupied by inappropriately placed patients. Patients wait, on average, 100.4 days for placement into chronic care beds and 63.6 days for placement into extended care beds. Through the Blue Run, the Task Force identified a deficit of 637 chronic care beds and 663 extended care beds in April 1983. Although a number of additional beds have become operational since the time of the study and more have been approved for operation, the growing number of elderly persons requiring these beds far surpasses their availability. Because of the length of time required for beds to be approved and then become operational, there presently still exists a severe shortage in chronic and extended care beds. This shortage requires that the approved beds become operational as soon as possible. The Task Force will make further recommendations as to the number of beds that will be needed by 1988 and 1993.

In addition, the Task Force has noted problems in the definitions of care currently in use leading to confusion as to the most appropriate levels of care for some patients. It has noted some special long term care populations who require special consideration beyond the mandate of this Task Force.

AGING OF THE POPULATION

The number of elderly in Metropolitan Toronto are expected to increase by 11% from 1983 to 1988 from 236,608 to 262,528. They will increase by a further 9.7% from 1988 to 1993 reaching 287,913 at that time. The population under age 65 is expected to decrease during these ten years by almost 78,000[3].

The aging of the population is very important in the issue of chronic care and extended care beds as the great majority of persons utilizing these beds on March 31, 1983 was elderly:

	Utilization of Beds	
	Population Under 65	Population 65 and Older
chronic care	25.1%	74.9%
extended care	5.3%	94.7%

CHRONIC CARE BED NEEDS

The Task Force identified a need for 3828 chronic care beds in April 1983. As there were 3191 chronic care beds in operation, this translates into a deficit of 637 chronic care beds. The need for 3828 chronic care beds can be expressed on a per capita basis as follows:

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3 Preliminary projections derived from the Metropolitan Toronto Planning Department. Subject to revision when projections from the Ontario Ministry of Treasury and Economics become available.

	Population Under 65	Population 65 and Older [4]
1983 population	1,899,950	236,608
Beds per 1000 population	.51 beds	12.11 beds

There are varying opinions as to the impact that chronic home care, more community health and support services, better health promotion efforts and coordination of services may have on the need for institutional services, if any. For example, a study in Manitoba found that the introduction of alternative care programs had no impact on geriatric blocking of acute care beds[5]. The Task Force concluded that no significant effect could be expected on the need for chronic care beds by 1988 but estimated that by 1993, the need for chronic care beds on a per capita basis might be reduced by up to 5%. The bed need projections then become:

	Population Under 65			Population 65 and Older			
Years	Projected Population	Beds per 1000 population	Bed Needs	Projected Population	Beds per 1000 population	Bed Needs	Total Bed Needs
1983	1,899,950	.51	962	236,608	12.11	2866	3828
1988	1,863,915	.51	951	262,528	12.11	3179	4130
1993	1,821,996	.48	875	287,913	11.50	3311	4186

There are currently 3153 approved chronic care beds in Metropolitan Toronto but 3191 beds are in operation. The Ministry of Health has approved for operation a number of additional chronic beds. These are:

---

[4] It would be more accurate to calculate bed needs for the young-old (65-74), middle-old (75-84) and old-old (85+) separately. Unfortunately, the population projections available at this time make such calculations impossible.

[5] Evelyn Shapiro, Noralou P. Roos, Steve Kavanagh, "Long Term Patients in Acute Care Beds: Is There a Cure?" The Gerontologist, Vol. 20, No. 3, 1980, p. 342-349.

Queensway General	120 (Etobicoke) December, 1984
Baycrest	94 (North York) June, 1985
Scarborough Centenary	80 (Scarborough) January, 1986
Salvation Army Scarborough Grace	65 (Scarborough) September, 1985

The Ministry of Health has also approved a number of chronic beds for planning but not yet for operation, These are:

Doctors Hospital	200 (approved June 1983) (City of Toronto)
West Park Hospital	24 (approved September 1981) (York)[6]

The immediate opening of the above beds would significantly alleviate the current chronic care bed shortage but it is anticipated that it is some time before this will occur. In the interim a shortage of chronic care beds will be experienced.

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[6] Special facility for mentally alert, physically disabled young adults.

RECOMMENDATION:

That the Ministry of Health approve for operation the chronic care beds that have already been approved for planning at Doctors Hospital and West Park Hospital.

The chronic care bed needs identified for 1988 and 1993 were 4130 and 4186. In order to meet these needs, 394 beds are required by 1988 or 450 by 1993.

Due to the artificial nature of city/borough boundaries in that facilities in one area serve residents of many areas, the Task Force chose not to recommend the allocation of chronic care beds by city/borough.

In March 1982, the Metropolitan Toronto District Health Council approved in principal proposals for additional chronic beds at Scarborough General Hospital and Sunnybrook Medical Centre.[7] In addition, the Long Term Care Committee has before it proposals for chronic care beds submitted by North York General Hospital, York-Finch General Hospital, Humber Memorial Hospital and Runnymede/Northwestern Hospitals.

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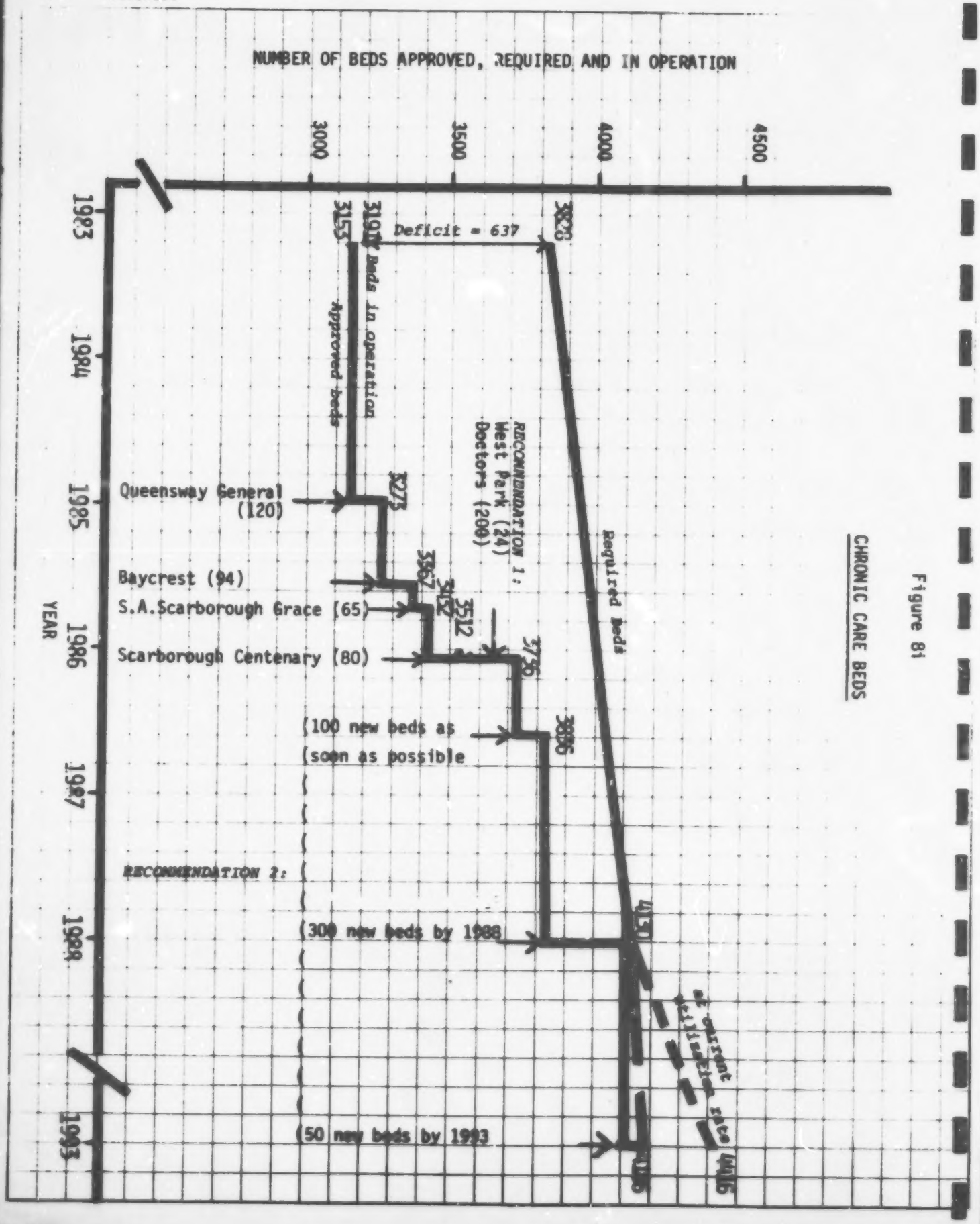
[7] Part of the "1982/83 Report of the Planning Committee Concerning Capital Projects and New and/or Expanded Programs" prepared for the District Health Council by the Hospital Council of Metropolitan Toronto.



CHRONIC CARE BEDS

Figure 81

RECOMMENDATION:

> ***That the Long Term Care Committee, through the Metropolitan Toronto District Health Council, recommend to the Ministry of Health the allocation of an additional 450 chronic care beds beyond those already approved for operation or planning by the Ministry of Health of which about 100 should be in operation as soon as possible, a further 300 should be in operation by 1988 and a further 50 by 1993.***

The chronic care bed situation is presented graphically in Figure 81. This Figure shows the number of chronic care beds required if current utilization rates were to continue as well as according to the assumptions made above. The approximate timing for additional beds to become operational and the timing of the recommended additional beds is shown. The recommended additions are spread over a ten year period.

EXTENDED CARE BED NEEDS

The Task Force identified a need for 8947 extended care beds in April 1983. As there were 8284 extended care beds in operation, this translates into a deficit of 663 extended care beds. This need for 8947 extended care beds can be expressed on a per capita basis as follows:

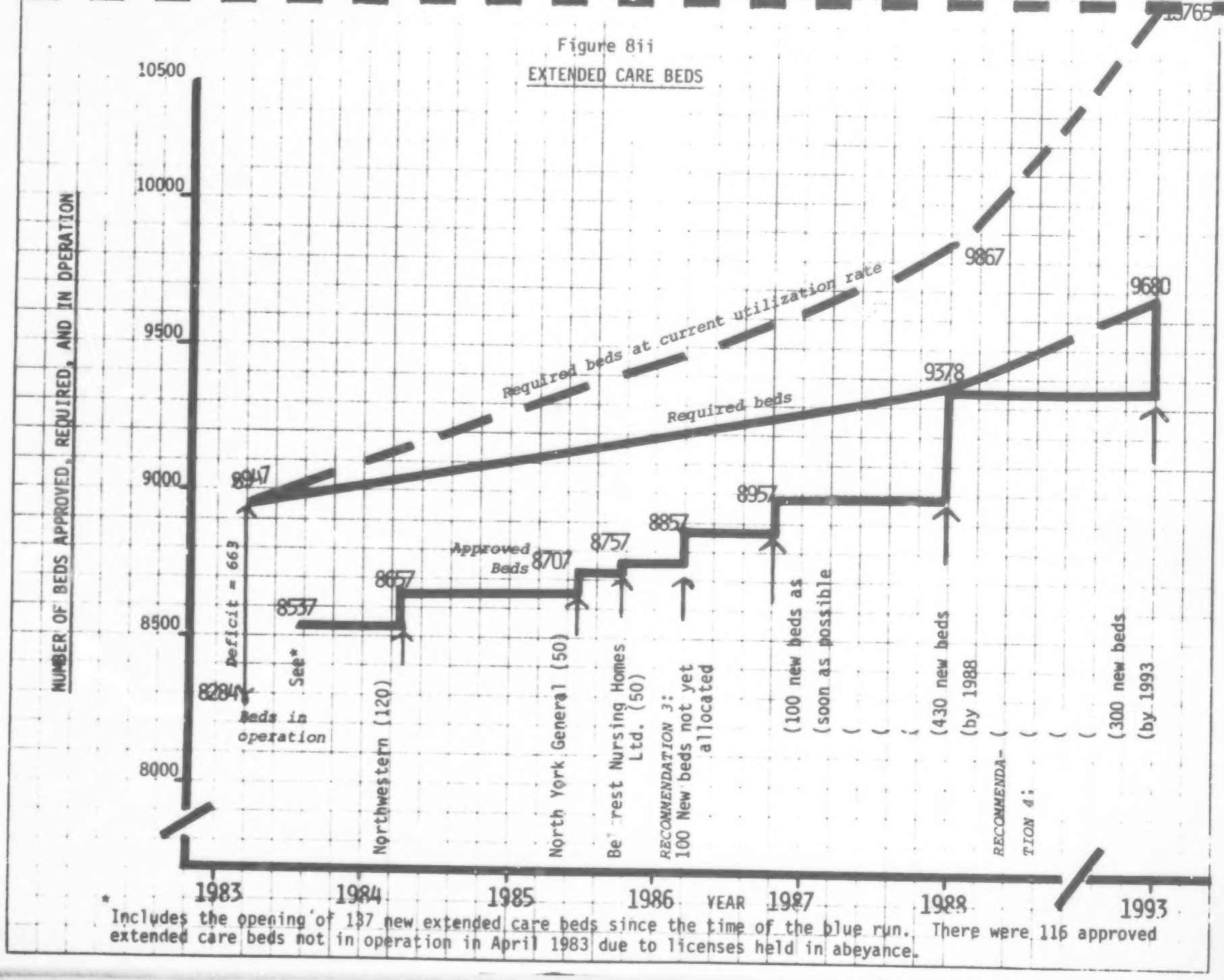
	Population Under 65	Population 65 and Older
1983 population	1,899,950	236,608
Beds per 1000 population	.25	35.81

In this case, the Task Force felt that community health and support services, such as the chronic home care program (to be implemented in March 1984) may have an impact on the need for extended care beds. It was hoped that these programs might reduce the need for extended care beds by 5% by 1988 and by an additional 5% by 1993. The bed need projections are:

	Population Under 65			Population 65 and Older			
Years	Projected Population	Beds per 1000 population	Bed Needs	Projected Population	Beds per 1000 population	Bed Needs	Total Bed Needs
1983	1,899,950	.25	473	236,608	35.81	8474	8947
1988	1,863,915	.24	447	262,528	34.02	8931	9378
1993	1,821,996	.22	401	287,913	32.23	9279	9680

Figure 8ii

EXTENDED CARE BEDS



* Includes the opening of 137 new extended care beds since the time of the blue run. There were 116 approved extended care beds not in operation in April 1983 due to licenses held in abeyance.

There are currently 8537 approved extended care beds. Two hundred and twenty beds have been approved and are under construction and an additional 100 beds have been announced but not yet tendered. Taking these beds into consideration, there is still an immediate need for an additional 90 beds, a further 431 by 1988 and a further 302 by 1993 for a total of 823 beds over and above the number currently approved.

Again, the Task Force decided not to recommend the allocation of extended care beds by city/borough.

RECOMMENDATIONS:

That the Ministry of Health award the 100 new extended care beds as soon as possible.

That the Ministry of Health and/or the Ministry of Community and Social Services approve for operation 100 new extended care beds to be in operation as soon as possible, and a further 430 to be in operation by 1988 and a further 300 by 1993.

The extended care bed situation is presented graphically in Figure 8ii. This Figure shows the number of extended care beds required if current utilization rates were to continue as well as according to the assumptions made above. The approximate timing for additional beds to become operational and the timing of recommended additions is shown. The recommended additions are spread over a ten year period.

OTHER RECOMMENDATIONS

In its review of Long Term Care Bed Needs, the Task Force identified a number of other issues that it believes require further investigation.

i) Heavy Extended Care

A group of patients has been identified that does not fit into either chronic or extended care. These patients are the 'heavy' extended care patients who require in excess of 2½ hours nursing and personal care per day.

The problems of this group of patients were identified through the blue run and the ongoing P.A.S.S. Information System. In the blue run, 331 inappropriately placed Metropolitan Toronto residents were identified as requiring heavy extended care. Heavy extended patients discharged during the 9 months of P.A.S.S. data collection, requiring heavy extended care waited longer to obtain placements in nursing homes than patients requiring light or medium extended care.

Current funding arrangements appear to be largely to blame for these problems. Since nursing homes receive the same per diem fee for each patient regardless of the number of hours of care required, there is no incentive for them to take in heavy care patients. In fact, the blue run identified 224 inappropriately placed patients in nursing homes who required chronic care but who were not on waiting lists.

In the majority of these cases, the nursing home had decided to keep the patient as long as possible. The funding situation in Charitable Homes for the Aged that provide extended care is similar. They are funded to a ceiling below that of nursing homes by the Ministry of Community and Social Services and must absorb any additional costs themselves. Municipal Homes for the Aged providing extended care have more flexibility in that any deficits incurred by the homes above the ceiling are cost shared 70:30 by the Ministry of Community and Social Services and the Municipality of Metropolitan Toronto. The blue run identified 201 inappropriately placed patients in extended care beds in homes for the aged who were not on waiting lists but whose optimal placements were in chronic care facilities.

Patients defined as requiring chronic care are expected to have a significant need for diagnostic and treatment services. However, there is little difference between a 'heavy' extended care patient and a chronic care patient of the maintenance stream. As a result of the extended care situation described above, chronic care beds are often filled with patients who should be in extended care but cannot be placed.

RECOMMENDATION:

That the Ministry of Health work with providers to review the definitions of light, medium and heavy extended care and to develop means of classifying extended care patients into these levels. Further, that the Ministry of Health fund facilities providing extended care according to the number of patients fitting each of these classifications.

ii) Rehabilitation of the Elderly

The Task Force believes that a more positive attitude must be developed toward rehabilitation services for the elderly as services are currently more oriented to young adults and children. This may be accomplished by a redefinition of general and special rehabilitation with a view to making the elderly more eligible and appropriate candidates for rehabilitation.

RECOMMENDATION:

That the Ministry of Health review its definitions of general and special rehabilitation in order to reflect the special needs of the elderly population.

iii) The Young Disabled

While only 7 persons under the age of 18 were documented by P.A.S.S. over a nine-month period as being discharged to long term care settings, the blue run identified 656 persons 18 and younger who were inappropriately placed but not on waiting lists. It appears that these patients are being maintained inappropriately in facilities due to a lack of more appropriate settings.

RECOMMENDATION:

That the Long Term Care Committee examine the special long term care bed needs of the young disabled.

iv) Other Special Care Groups

The Task Force is aware of other special care groups that require special consideration beyond its mandate.

RECOMMENDATION:

That the Long Term Care Committee examine the special long term care bed needs of other care groups such as the patients with chronic neurological disorders, chronic psychiatric disorders and others.

v) Palliative Care

The blue run identified 166 inappropriately placed patients whose optimal placement was chronic care of the terminal type. There are currently 91 palliative care beds in Metropolitan Toronto. In order to examine the full range of palliative care services and needs, the Task Force recommends:

RECOMMENDATION:

That the Long Term Care Committee work with the Palliative Care Work Group of Metropolitan Toronto to examine and develop a comprehensive range of appropriately-funded palliatve care services (community and institutional) throughout Metropolitan Toronto.

vi) Residential Care Beds

Homes for the Aged are experiencing vacant beds in their residential care section and waiting lists for their extended care beds. In order to make best use of existing facilities, it is recommended that:

RECOMMENDATION:

That the Ministry of Community and Social Services establish a Task Force with Charitable and Municipal Homes for the Aged as well as with private residential care facilities to examine the current role of residential care beds and develop, where necessary, more appropriate roles and functions for existing beds such as the possible conversion to extended care.

vii) Range of Services

The Task Force supports the concept of several levels of care at a single facility and encourages the addition of chronic beds to existing hospitals, and extended care beds to facilities that provide residential care.

viii) Evaluation of the P.A.S.S. Information System

The Task Force's Terms of Reference included the evaluation of P.A.S.S. as a planning tool for long term care in Metropolitan Toronto at the end of one year of its implementation. The Task Force believes that the comments from the institutions that contributed information to P.A.S.S. are essential in order to make this evaluation. However, their comments cannot be expected until they have had a chance to review this report. The Task Force will defer this item until the spring of 1984 at which time providers will be asked for their comments on this issue. This Task Force will then present a supplementary report to the Long Term Care Committee.

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A Note about the Appendices:

Because of the size of the appendices (almost 400 pages), they have been prepared as six separate documents and can be obtained individually as such:

1. Study Methodologies (43 pages).

2. Definitions and Utilization Patterns of Long Term Care Beds in Metropolitan Toronto (60 pages).

3. Results of P.A.S.S., October 1, 1982 to June 30, 1983 (135 pages).

4. Results of the Blue Run (88 pages).

5. Validation of the Blue Run of the Placement and Support Services Information System (27 pages).

6. Calculations of Long Term Care Bed Needs in Metropolitan Toronto. (30 pages).